The Honorable Peter J. Roskam

507 Cannon House Office Building
Washington, D.C. 20515
(202) 225-4561
(202) 225-1166 (Fax)

150 S. Bloomingdale Road, Suite 200
Bloomingdale, IL 60108
(630) 893-9670
(630) 893-9735 (Fax)

To: DoNAVY / Cons. Affairs Fax: 703 614 7089

Date: 29 JUN 10 Phone:

From: (b) (6)

Benefits concerns
-002C

Number of Pages (Including cover sheet): 1

COMMENTS:

PETER J. ROSKAM
6TH DISTRICT, ILLINOIS

DEPUTY WHIP

COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEES:
OVERSIGHT
INCOME SECURITY AND FAMILY SUPPORT
SELECT REVENUE MEASURES

Congress of the United States
House of Representatives
Washington, DC 20515–1306

507 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-4561
(202) 225-1166 FAX

150 S. BLOOMINGDALE ROAD
SUITE 200
BLOOMINGDALE, IL 60108
(630) 893-9670
(630) 893-9725 FAX

www.roskam.house.gov

June 29, 2010

Department of the Navy
Congressional Affairs
Fax: (703)614-7089

Dear Congressional Liaison,

My constituent, (b) (6) [redacted], has requested my office to make an inquiry regarding the status of their case.

I would greatly appreciate any information you are able to provide. If you have any further questions or need clarification please contact my staff member, (b) (6) [redacted] at 630-893-9670. Thank you for your time and attention.

Very truly yours,

Peter Roskam

Peter J. Roskam
Member of Congress

PJR/av

Your signature on this document is required for assistance

Privacy Release Form
Congressman Peter Roskam, 6th Congressional District, IL

Under the Privacy Act of 1974, Federal Agencies are prohibited from releasing any information regarding an individual without written consent. Therefore, I hereby give you and your staff permission to make inquiries into my records kept by the:

(List the Federal Agency Here) United States Navy

Nam (b) (6) [redacted]

Stree [redacted]

City [redacted]

Cell [redacted]

Date [redacted]

Veterans Claim Number (if applies) _____

Military Identification Number (if applies) _____

Other numbers identifying my case _____

Types of benefits I am seeking _____

Date and Place claim was filed 13 May 2010 San Diego, CA

Please write a brief description of the problem with which you are requesting assistance (attach copies of additional documentation):

The major issue I am having is that I have served in the USN for the last 10.5 years and now that someone says that I fail to meet perform to serve standards but gives no reason and the medical system is trying to do a medical evaluation board for to see if I am fit for duty. The big Navy is saying that since I cannot get my package all the way to Washington D.C by 13 August 2010 that I have to leave the service with no compensation from the Navy. All I will get is what the VA is going to give me. Having nerve damage in both arms from shoulder to finger tips and loosing strength and the ability to do any job but administration jobs I see as a problem.

Signat (b) (6) [redacted] Date 23 June 2010

Please return to :
Congressman Peter Roskam
150 South Bloomingdale Road, Suite 200
Bloomingdale, IL 60108

OMB Approved No. 2900-0704
Respondent Burden: 30 minutes

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)
2010 JUN 9 AM 7 20

VA/DOD JOINT DISABILITY EVALUATION BOARD CLAIM

IMPORTANT - Please read the Privacy Act and Respondent Burden on the back before completing the form.

Section I: To be completed by Military Treatment Facility referring Service member to Disability Evaluation System *(DES)*

SERVICE MEMBER NAME *(First, middle, last)* (b) (6)	GRADE (b) (6)
COMPONENT: FLEET READINESS CENTER WEST LEMOORE	UNIT ADDRESS: 160 L Street, NAS Lemoore, CA 93246-5049
(b) (6)	DATE OF BIRTH (MM,DD,YYYY) (b) (6)
	SEX: [X] MALE [ ] FEMALE
NAME AND PHONE NUMBER OF ASSIGNED PHYSICAL EVALUATION BOARD LIAISON OFFICER *(PEBLO)* (First, MI, Last): (b) (6) / Include Area Code: 619-532-8322	NAME OF REFERRING MILITARY TREATMENT FACILITY *(MTF)*: NAVMEDCEN SAN DIEGO, CA
	DATE OF REFERRAL TO MEDICAL EVALUATION BOARD *(MEB)* (MM,DD,YYYY): 06/09/2010

MEDICAL CONDITIONS TO BE CONSIDERED AS THE BASIS OF FITNESS FOR DUTY DETERMINATION *(List only conditions referred by physician)*:

1. THORACIC OUTLET SYNDROME (ICD-9 353.0)

PREPARED BY (b) (6)	DATE PREPARED: 06/09/2010

Section II: Tell us about yourself. Please provide a contact name and address. If you are on Temporary Duty, please indicate that on the VA Form 21-4138, Statement in Support of Claim available on the internet at www.va.gov/vaforms

1. WHAT IS YOUR ADDRESS? (b) (6) City / State / ZIP Code / Country	2. WHAT ARE YOUR TELEPHONE NUMBERS? *(Include Area Code)* Daytime (b) (6) / Evening / Cell phone
3. WHAT IS YOUR E-MAIL ADDRESS? (b) (6)	
4. HAVE YOU EVER FILED A CLAIM WITH VA? [ ] Yes [X] No *(If "Yes," provide file number)* *(VA File Number)*	5. POINT OF CONTACT NAME AND ADDRESS
6a. DID YOU SERVE UNDER ANOTHER NAME? [ ] Yes *(If "Yes," go to item 6b)* [X] No *(If "No," go to item 7)*	6b. PLEASE LIST OTHER NAME(S) YOU SERVED UNDER
7. I ENTERED THIS CURRENT PERIOD OF ACTIVE SERVICE ON: 01 (mo) / 31 (day) / 2000 (yr)	8. PLACE OF ENTRY: CHICAGO, IL (b) (6)

Section III: Tell us about your military service. Enter complete information for your service. Tell us about your reserve duty or National Guard Duty

9. ARE YOU CURRENTLY ASSIGNED TO AN ACTIVE RESERVE, UNIT OR NATIONAL GUARD UNIT? [ ] Yes *(If "Yes," provide date of activation below)* [X] No ___ / ___ / ___ (mo / day / yr)	10a. WHAT IS THE NAME AND MAILING ADDRESS OF YOUR CURRENT UNIT? COMMANDING OFFICER, FRC WEST LEMOORE, 160 L Street, NAS Lemoore, CA 93246-5049	10b. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? *(Include Area Code)* (559) 998-1672

Addendum to VA Form 21-0189

Block 8. Additional Conditions – (Do you have any disabling conditions, other than those referred for the fitness for duty determination, that you feel were caused by, or aggravated by, your active military service?) Please list those disabilities below:

1. bilateral ear tinnitus
2. left ear hearing loss
3. allergic rhinitis
4. bilateral foot plantar warts
5. bilateral knee osgood schlatters disease
6. gastroenteritis
7. stomach pain
8. hypertension

Name: (b) (6) [redacted]
Des Case# 10799

Signature: (b) (6) [redacted] **Date:** 9 June 2010

(b) (6)

From: (b) (6)
Sent: Friday, June 11, 2010 11:00 AM
To: (b) (6)
Cc:
Subject: APPOINTMENTS

Attachments: image001.gif

image001.gif (2 KB)

Good morning,

The following appointments are for your medical board. Please review them and call me if you have questions. All appts will be here in Mission Valley, third floor, room 3315. The address is below in my contact information. I look forward to speaking with you.

Jun 11, 2010@10:55:33 Page: 1 of 1

Patient: (b) (6) Outpatient

Total Appointment Profile * - New GAF Required 06/04/10 thru 03/06/13

	Clinic	Appt Date/Time	Status
1	Mv Med Comp Corey	07/16/2010@10:00	Future
2	Mv Surg Comp Robinson	07/16/2010@11:00	Future
3	Mv Comp Audio Am	07/16/2010@12:00	Future

Take care,

(b) (6)

Department of Veterans Affairs

Compensation and Pension

8810 Rio San Diego Drive

San Diego, Ca 92108

619-400-5225work

619-400-5031 Fax

PEB / DES PILOT PROGRAM INFORMATION SHEET

PEB - Physical Evaluation Board
DES - Disability Evaluation System
VA - Veterans Affairs

1. Your doctor / specialist is referring your case to PEB for adjudication - fit or unfit to continue active duty. Your case will be assigned to a Medical Board Case Manager here at Naval Medical Center, San Diego (Balboa Hospital).

2. Your Case Manager will call you to schedule an appointment to see the VA Counselor. Please be patient and wait for the call. On your appointment with your medical board case manager, he/she explain to you the medical board process, the DES pilot program, and answer any question you may have about PEB. If you have not received a phone call after 30 days, call 619-532-7493. While waiting for the phone call from your assigned case manager, make 3 copies (one-sided copy) of your medical record, 1 for PEB, 1 for VA, and 1 for yourself.

3. The VA counselor will discuss and explain to you VA claims and benefits. In order to see the VA Counselor, you must bring 2 copies (one-sided copy) of your medical record. The VA Counselor will give you counseling and schedule and appointment for your physical exam at the VA Clinic.

4. After you see the VA Counselor, you will get a phone call for your appointment at the VA Clinic (Mission Valley or La Jolla), directions to the clinic will be provided to you. You cannot cancel these appointments unless you have an emergency matter to attend to as these appointments are paid for by the Navy and Marine Corps. If you encounter any problem with your appointment, call your Medical Board Case Manager.

5. After your physical exam and other medical appointments at the VA, your Medical Board Case Manager will wait for the VA reports. While waiting for the VA physical exam reports, you need to ask / check with your chain of command status of your Non-Medical Assessment (NMA) letter. It is your responsibility to give a copy of your NMA to your Medical Board Case Manager. In addition, if Line of Duty Investigation (LODI) is required, you are responsible to get a copy of the completed LODI to your Med Board Case Manager.

6. Your Med Board Case Manager will mail your package to PEB when the following documents are received:

   a. Copy of your medical record
   b. VA physical exam report
   c. Non-Medical Assessment (NMA)
   d. LODI if applicable

JOINT DoD / VA DISABILITY EVALUATION PILOT REFERRAL

H

SECTION 1: MILITARY TREATMENT FACILITY REFERRAL

(b) (6)

Diagnosis 3. _____ Initial Prescription _____ MM / DD / YYYY

* List all diagnoses that [redacted] active duty in a medically unrestricted status. Use continuation sheet.

(b) (6) LCDR (MC) (USN)

Provider Name:

Signature:

05 / 13 / 2010 MM / DD / YYYY

SECTION 2: PATIENT INFORMATION (TO BE COMPLETED BY PATIENT OR HIS/HER DESIGNEE)

I understand that I am being referred to the joint DoD / VA Disability Evaluation System Pilot process for a fitness for continued military service determination and possible referral to the Department of Veterans Affairs for the evaluation and assignment of a disability rating for those medical conditions (diagnoses) that are determined to be Service connected. I further understand that I will be provided an opportunity to claim other medical conditions before my case is referred to the VA Rating Board.

I ☐ DO ☒ DO NOT desire to comment on the content of this referral

(see attachment)

(b) (6)

Patient Signature

05 / 13 / 2010 MM / DD / YYYY

SECTION 3: PHYSICAL EVALUATION BOARD LIAISON OFFICER/MEDICAL BOARD CASE WORKER

1. Date Referral Received: 14 MAY 2010 MM / DD / YYYY
2. DES Case ID (For example A-00012-1): 10799
3. Service member counseled on DoD DES Pilot: 08 JUN 2010 MM / DD / YYYY
4. Date DES Case file forwarded to Military Service Coordinator: 09 JUN 2010 MM / DD / YYYY

MARCUS T.W. HARRIS

PEBLO / MEB Case Worker Name:

(b) (6)

Signature:

08 JUN 2010 MM / DD / YYYY

SECTION 4: MILITARY SERVICES COORDINATOR (VA REPRESENTATIVE)

1. Date DES Case file received: 06/09/2010 MM / DD / YYYY
2. Date Service Member Counseled on VA DES Pilot Process: 06/09/2010 MM / DD / YYYY
3. Date VA / DoD Joint Disability Evaluation Form (VA Form 21-0819) Completed: 06/09/2010 MM / DD / YYYY
4. Date Referred for Required Medical Exam (VA CAPRI / VERIS): _____ MM / DD / YYYY
5. Date DES Case file forwarded to referring Military Treatment Facility: _____ MM / DD / YYYY

SECTION 5: MILITARY TREATMENT FACILITY (Follow-up Medical Evaluation Board Actions)

1. Date DES Case file received (PEBLO / MEB Case Worker): _____ MM / DD / YYYY
2. Date Narrative Summary signed (Provider / PEBLO / MEB Case Worker): _____ MM / DD / YYYY
3. Date DES Case sent to MEB (PEBLO / MEB Case Worker): _____ MM / DD / YYYY
4. Date MEB [illegible] completed (Medical Board): _____ MM / DD / YYYY
   - ☐ Case returned [illegible] additional treatment required
   - ☐ Service [illegible] medically acceptable
   - ☐ Service [illegible] US Physical Evaluation Board
5. Date Service member notified of MEB findings (PEBLO / MEB Case Worker): _____ MM / DD / YYYY
6. Date DES Case file forwarded to Service PEB (PEBLO / MEB Case Worker): _____ MM / DD / YYYY